

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-001932

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 619

STATE FILE NUMBER

## 1. PLACE OF DEATH

a. COUNTY **Jackson**

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE **Missouri** b. COUNTY **Jackson**

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN **Kansas City**

Length of stay in lb

**30 Yrs**

c. CITY

OR TOWN **Kansas City**

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION **St Joseph's Hospital**

Inside Limits

Yes ☒ No ☐

d. STREET

ADDRESS **5412 E 12th St**

(If outside, give location)

Reside on Farm

Yes ☐ No ☒

## 3. NAME OF DECEASED

(Type or print)

First **ROSA**

Middle **M**

Last **PARKER**

4. DATE

OF DEATH

Month **February**

Day **1**

Year **1962**

## 5. SEX

**Female**

## 6. COLOR OR RACE

**White**

## 7. Married

☒ Never Married ☐

Widowed ☐ Divorced ☐

## 8. DATE OF BIRTH

**5/17/04**

## 9. AGE (last birthday)

**57**

## IF UNDER 1 YEAR

Months **7** Days **1**

## IF UNDER 24 HR

Hours **1** Min. **0**

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (City and state or country)

**Fairbury Neb**

## 12. CITIZEN OF WHAT COUNTRY

**USA**

## 13a. FATHER'S NAME

**Ernest C Bowman**

## 13b. MOTHER'S MAIDEN NAME

**Rosa Reed**

## 14. NAME OF HUSBAND OR WIFE

**James W Parker**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

**No**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Address

**James W Parker 5412 E 12th**

## 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Myocardial infarction**

## INTERVAL BETWEEN ONSET AND DEATH

**7 weeks**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

**Generalized arteriosclerosis**

**unknown**

DUE TO (c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

**Cerebral thrombosis**

## PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

## 19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

## 20a. ACCIDENT

☐

## SUICIDE

☐

## HOMICIDE

☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

## 20c. TIME OF INJURY

Hour

a.m.

Month, Day, Year

## 20d. INJURY OCCURRED WHILE AT WORK

☐ NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

## COUNTY

## STATE

21. I attended the deceased from **12/2/61** to **2/1/62** and last saw her alive on **2/1/62**

Death occurred at **St. Joseph Hosp - 640 P** on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

**E. E. Van Buskirk M.D.**

(Degree or title)

## 22b. ADDRESS

**5246 St. John KCMo**

## 22c. DATE SIGNED

**2/2/62**

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

## 23b. DATE

**2/5/62**

## 23c. NAME OF CEMETERY OR CREMATORY

**Mt Washington Cem**

## 23d. LOCATION (City, town, or county)

**Independence Mo**

## 24. FUNERAL DIRECTOR

## ADDRESS

**Sheil Funeral Home Kansas City Mo**

## 25. DATE RECD. BY LOCAL REG.

**2-2-62**

## 26. REGISTRAR'S SIGNATURE

**Ruth Long**

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

E. Van Buskirk

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.